ImpAct 11

- sharing experience
- defining good practice
- improving service delivery
- supporting learning in the NHS

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NHS Learning Network

Getting in shape

Finding ways and means to help members of clinical teams make their full contribution is a continual challenge. As services roll on, getting ever busier, it is often difficult to find the space and time to have a fresh look at what we do. *Are we making the best use of skills in the team? Do I need to do this? Can we streamline the process for patients*? These are three questions that are asked frequently. We know from **ImpAct** case studies that the best innovations happen when people make their own space and time to answer these questions.

The four case studies in this issue of **ImpAct** all feature services where effort was made to make better use of skills already available. In each , development work showed that tasks could be shared, new roles defined, systems improved and ways found to respond to the ever increasing demand on services. The lessons are relevant across the NHS.

Electronic ImpAct

Delivering Better Health Care

Over the last ten years considerable effort has been devoted to trying to understand the issues involved in changing clinical practice. A lot of lessons are being learnt. There is not space here to cover these interests so over the next few months we will be posting a series of papers to Electronic **ImpAct**. The first will tackle the issue by pointing to things that can go wrong: *some elephant traps to avoid* (www.jr2.ox.ac.uk/bandolier/booth/mgmt/BetterHC.html). Subsequent papers will build on this starting point and four key questions that need to be addressed:

- *What do you need to know? The knowledge which should influence the work.*
- *What needs to be done? Getting a clear picture of the range of tasks involved.*
- *How to make it happen? The skills and resources needed.*
- *Where to find help? Don't reinvent the wheel.*

Reducing DNAs

In March 2000 we featured two case studies describing initiatives to try to ensure that patients turn up for their appointments. DNAs are a continuing problem people running clinics have to tackle. A successful project to tackle DNAs in primary care features in the management section of the ***Bandolier*** Internet site (www.jr2.ox.ac.uk/bandolier/booth/booths/mgmt.html).Dr Ken Menon, a GP in Ongar, Essex has virtually eliminated DNAs at a direct-access vasectomy clinic. An active approach to managing the waiting list and careful attention to detail has kept the numbers to the very minimum, with only one DNA out of 276 over two years. The work is a real success.

An informed approach to cardiac care

Where are we now? This is the question primary care has to answer as it looks to improve quality of care provided. Reliable information about patients on the practice lists and their current treatment is essential. But answering the question is not easy. The variability of practice-based systems can be a real problem.

ImpAct has learned about a team working with primary care to tackle these problems. Based at St George's Medical School, the Primary Care Data Quality (PCDQ) project has four years experience of working with MIQUEST software to help primary care extract useful data from local systems. Working through an education process the team helps people value information and develop their skills in accessing and interpreting data. We've posted a paper that describes their work. They have had a good deal of success working with three primary care groups (with 25 practices). Measurable improvements in practice have been achieved as well as improvement in recording. It's well worth a look (www.jr2.ox.ac.uk/bandolier/booth/mgmt/PCDG.html).

Better prescribing in nursing homes

Systematic review of repeat prescribing in nursing homes in Leicester improved the quality of care and saved over £80 per patient per year. The implication for the NHS is releasing resources amounting to £100 million a year (www.jr2.ox.ac.uk/bandolier/booth/mgmt/Nurhomed.html).

In this issue

Electronic *ImpAct* on www.ebandolier.com/ImpAct

TACKLING DELAY IN ORTHOPAEDICS

Providing a physiotherapy outreach service in primary care in Doncaster.

Why was the initiative launched?

Since 1996 two orthopaedic physiotherapy practitioners have worked with consultant orthopaedic surgeons to provide an initial assessment of newly-referred patients. Only those patients needing a surgical opinion were seen by the consultant. This helped reduce the pressure on consultant time and significantly reduced waiting time.

After initial success it proved difficult to continue to meet targets and increase activity. There was a limit to the number of secondary care clinics because consultants only held one or two outpatient clinics a week. Managers wanted to explore whether orthopaedic physiotherapy practitioners could work with GPs to reduce the number of orthopaedic referrals, and thereby further reduce waiting times.

What was done?

A group of experienced practitioners working with the consultant orthopaedic surgeons tackled the preparatory work for the new initiative. They revised the protocol used in hospital for relevance in primary care. It defined the range of tasks to be undertaken, the nature of medical cover required, and arrangements to fast track patients needing to be seen by a consultant. The practitioners shadowed consultants to help equip themselves for their new role. An important aim was to maintain the links between practitioners and consultants. A detailed activity analysis was undertaken to demonstrate the success of the new approach.

In summer 1999 a training seminar on management of acute low back pain was arranged for local GPs as part of the PGEA programme. It was an opportunity to promote the role of orthopaedic physiotherapy practitioners. GPs were impressed by the presentations and the potential offered by the new service, and agreed to identify practices to pilot the new approach. Questions needed to be resolved about the funding of the administrative costs involved, but eventually two practices in each PCG area agreed to take part in the six-month trial (six practices in all).

Plans for the clinics in primary care

Each pilot practice started with one clinic a month from September 1999. Practices were asked to keep to one side possible referrals to secondary care and the orthopaedic physiotherapy practitioner reviewed them to recommend whether patients be seen at the clinic in primary care or referred to a consultant. Practices were encouraged to send urgent referrals to the hospital and not wait for a physiotherapy practitioner visit or clinic. The patient letter explained how the system worked and made clear that a referral to the consultant could proceed if patients wished.

Good timing

The health authority was under increasing pressure to address long orthopaedic waits and agreed to provide funding for three years for an additional orthopaedic physiotherapy practitioner. This allowed the initiative to be extended to another 13 practices with high referral rates.

A new the orthopaedic physiotherapy practitioner was appointed in October 1999. The three orthopaedic physiotherapy practitioners decided that each of them spend time in primary care, secondary care and in the physiotherapy department. This rotation ensured that they retained a balanced set of skills.

Did it work?

The primary care initiative had a marked impact on referrals. Over the first seven months (September 1999 to March 2000) fewer than 10% of patients seen by the orthopaedic physiotherapy practitioner were referred to a consultant (Table 1). The waiting time is now down to about 3 or 4 weeks. Table 2 compares the rates of referrals in practices with orthopaedic physiotherapy practitioners clinics with other practices in Doncaster. The situation is complicated by other local initiatives to tackle waiting lists. GPs regularly contact practitioners for advice. The service is being extended to all practices in the Doncaster area.

Patient reaction

Patients like the new approach. Not one seen in primary care has insisted on being referred to the consultant. This echoes the experience in secondary care, with only a handful over the four years demanding to see the consultant.

The responsiveness of the system is illustrated by the experience of one patient seen at the monthly clinic. It was clear to the orthopaedic physiotherapy practitioner that this patient had a serious back problem and needed to be seen urgently by the consultant. The fast track arrangement meant that the patient was seen the following week at the consultant's clinic. Under the old arrangements the wait would have been several weeks. The level of care each patient receives is appropriate to the severity of their problem: doing the right thing right, and at the right time.

Table 1: Care paths for patients seen by orthopaedic physiotherapy practitioners at primary care clinics in Doncaster:

	Sept 1999 to Mar 2000	
	Patients	**Percent**
Referred to Orthopaedic Clinic	40	7.4
Referred to Pain Clinic	3	0.6
Discharged	128	23.7
Referred to physiotherapy	306	56.6
Injected	34	6.3
Follow up by OPP	30	5.5
Total	541	100

Tips for success

- √ Make sure plans allow sufficient time to develop relationships with new organisations in primary care: you are competing with a very busy agenda.
- √ A pilot phase can test new ideas. Constantly re-evaluate the service and feed back the impact and successes.
- √ Make sure that patients understand the consequences of your initiatives: respect their wishes if they want to go through traditional routes.
- √ Be incremental: in Doncaster a sound base in secondary care ensured that rapid progress could be made when the initiative moved into primary care.
- √ Teams are effective when members trust one another. Promote understanding of new roles and work hard on links between practitioners and GPs.
- √ Involve everyone affected when sorting out operational issues: don't forget clerical staff.
- √ Make sure that necessary clerical support is available.
- √ Make sure that resources exist before looking at ways to increase referrals.

Table 2: Impact of orthopaedic physiotherapy practitioners (OPP) on referrals

	Numbers of referrals		Change	
	98/99	99/00	Number	Percent
PCG 1				
With OPP	563	421	-142	-25
Without OPP	479	544	+65	+14
PCG 2				
With OPP	739	598	-141	-19
Without OPP	533	538	+5	0
PCG 3				
With OPP	837	554	-280	-33
Without OPP	1160	1064	-96	-8

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The following materials are available:
Referral protocols for use in primary and secondary care.
Job description for orthopaedic physiotherapy practitioners.

ImpAct bottom line

⇒ **Build a history of success to help move posts from project to recurrent funding: be patient because it can take several years to get to this stage!**

A PILOT APPROACH TO CHANGE WAYS OF WORKING IN PRIMARY CARE

Building on success with a nurse-led hypertension clinic at Bewdley Medical Centre

What prompted the initiative?

In the early 1990s Bewdley Medical Centre realised GPs were under too much pressure. They wanted to maintain or improve standards but this was becoming impossible. Demands from patients were increasing without enough doctor time to meet them. Fundholding (and then total purchasing) offered opportunities for innovation with management of chronic conditions a suitable candidate for change. Traditionally these patients were always seen by the GP, but it seemed probable that nurses could manage these consultations. Research evidence was providing a strong lead towards the essential components of effective care for patients with hypertension.

How was the work taken forward?

Developing nurse-led clinics needed a new approach to teamwork in primary care and a radical move away from the clinical independence of GPs. It would take time to develop an approach where all members of the team worked to common standards. The intention was to empower nurses as members of the team rather than define a set of tasks to be delegated. The practice needed to work together.

With no model for nurse-led clinics Dr Robert Marriott asked practice nurses to work with him to set up a hypertension clinic: get going and see how the idea evolved. The process worked well with growing confidence in the new approach in the first year. Patients were referred to the nurse for assessment and treatment. Audit confirmed the quality of care being provided. The pilot study showed what was possible, but a more deliberate plan was required if the concept was to be adopted by the whole practice. Work was needed on the development of guidelines, information systems, on training and on team development.

Creating local guidelines

Informal enquiries uncovered variation between partners. These variations would have to be addressed if a new system of nurse-led clinics was to be effective. The challenge was to assemble evidence on which the partners could rely at a time when the general understanding about evidence-based practice was in its infancy. A guideline for the care and treatment of patients with hypertension was developed and adopted by the practice. The practice learnt how to adapt national guidelines to meet local needs and manage

Table 1: Hypertensive and IHD patients: BP levels

Bewdley Practice	Comparison
60% of hypertensive patients have BP below 160/90	(BMJ 1996; 313 :93-96) Study of 876 hypertensive patients in primary care and found that 46% were well controlled with BP 160/90 or below.
35% of patients with IHD meet the new standard of BP below 140/85	(J Hypertens 1998; 16 : 747-753) Study reported that only 6% of UK hypertensives were reaching the target levels set by the British Hypertensive Society.

them within available resources. The key to success was flexibility and focus on patient: what was reasonable for the individual patient, rather than continually striving for the guideline standard.

Moving from paper records

When the first nurse-led clinic was set up traditional paper based records were used, though a structured record system would be required to monitor patient management. There was no ready-made solution, but a chance encounter at an IT conference in 1993 enabled the practice's computer manager to learn about a promising new system. This would allow the practice to develop its own template rather than require it to work with systems developed elsewhere. This was a major leap forward. A template for the hypertension clinics was developed which not only provided a practical management system but also allowed past practice to be reviewed at the press of a button.

Equipping nurses for their new role.

Some practice nurses were anxious about taking on extra responsibility when the new clinics were first mooted. Training courses were not available because at that time few people had experience of managing nurse-led clinics. Training in the practice was organised taking their local guideline as a starting point. The aim was to create a spirit of team working to allow nurses to gain confidence in their new role.

What difference did it make?

The model for the hypertension clinic has been a resounding success, providing high quality care. There is little outcome data on hypertension in primary care, but the care at Bewdley compares with achievements elsewhere (Table 1). The success was reflected in Dr Marriott being named *Doctor of the Year* in 1999, when the practice was also given Beacon status. This success has encouraged nurses to develop their skills, experience and role in the team. Practice and district nurses are involved, and probably know more about the management of hypertension than their GP colleagues!

Building on success

Effective team working has allowed the model for nurse-led clinics to be adopted for several other chronic conditions including diabetes, heart failure, and asthma. These all help to improve quality of care. Key features are creating **local** guidelines, preparing a **template** for records and **training**. Guidelines are reviewed several times a year to ensure relevance. The use of templates means that all information is Read-coded and entered in the records in a standard way. Auditing is made easy and regular meetings reinforce the process of team working.

The changes have allowed GPs to increase consultation time from seven minutes to about 10 minutes per patient. Relationships with consultants have improved: they now have confidence in the quality of referrals from Bewdley because patients are referred appropriately.

The investment in team building has borne fruit. It has had a significant impact on working relationships in the team and helped strengthen the spirit of teamwork. The practice seeks to recognise and work with conflicting interests and views and not sweep them under the carpet. External facilitation has played a big part here. The aim is to build on the different abilities rather than expect everyone to be the same. Referrals across disciplines are now a normal way of working, from doctor to nurse, from nurse to doctor, from therapist to doctor.

The overwhelming reaction from patients has been positive. After much effort to explain the new approach, they are used to seeing the nurse as a first point of contact rather than expecting to see a doctor as a matter or course. A later development was the creation of a patient advisory group to help ensure that on-going developments are sensitive to the views of patients. Other developments being planned include the encouragement of patients to monitor their own blood pressure with home monitoring kits.

Tips for success

- √ Don't be afraid to try something new.
- √ Don't wait for help because it might never come! Find your own solutions.
- √ Effective team relationships don't just happen. They take time, but there is no end of the road when you can say *done that*.
- √ Effective teams require leadership, a sense of direction, good organisation and efficient communications.
- √ Information is a major component of effective care; investment of time and energy to get the right system will be well spent.
- √ Create records systems that support audit and review and don't rely on someone looking for paper records.
- √ Don't be fazed by IT: there are practical ways to develop IT solutions locally. Find the right person to help you.

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Further information is available from the Centre's website (www.bewdleymedicalcentre.force9.co.uk), including the Centre's Annual Report and clinical guidelines.

ImpAct bottom line

⇒ **Avoid the impression that the aim is to delegate tasks. Seek to empower those involved.**

SHARED CARE – A BETTER WAY OF WORKING

Shared care prostate clinic at Colchester Hospital, a model of clinical research and development.

Why was the initiative launched?

In the early 1990s the Department of Urology at Colchester Hospital was facing pressures. There was growing patient demand when the focus for funded development work was in primary care, not in hospitals. Creative thinking and action was required. Because of pressure on resources in the Trust solutions would have to be found elsewhere. The Department decided to use research funds made available through donations and collaborative research.

What steps were taken?

To retain control over research the Urology Department sought external funding from Colchester Catalyst Charity to help them set up an organisation to manage their research activities. With a substantial grant (£20,000) they set up their own charitable company, URINE: Urology Research in North Essex. URINE had three objectives: to research new technology, to development new technology and to develop the role of specialist urology nurses.

Since URINE was founded it has developed an extensive research programme. From an **ImpAct** perspective the attraction is the work undertaken to develop the role of specialist urology nurses, and a model for shared-care prostate clinics. To meet growing demand the aim was to find ways to use skills of GPs, the specialist nurse and consultant to the best effect: could a practical way be found to share the necessary tasks? A team led by Urologist Chris Booth decided that they needed a means to test their ideas for a shared-care, nurse-led, consultant-backed, prostate clinic.

Setting up a pilot clinic

A pilot service was based at Clacton Hospital, a large cottage hospital in the Trust. The unit dealt with 44 GPs serving an elderly population where there was a high level of demand. Another attraction was that it was the base for two nurses keen to develop a new role for nurses in urology. Preparation for the pilot involved the design of a structured referral protocol for use by local GPs and a structured interview schedule for use in the prostate clinic. The team also arranged training sessions so that nurses running the clinic had the knowledge and skills necessary.

The ideas for a shared care clinic were presented to GPs in 1993. GPs were encouraged to use the referral protocol instead of the traditional referral letter. To minimise workload on GPs no prior investigation was required and GPs were asked only to indicate the predominant urological symptom, relevant history and drugs prescribed. A specialist nurse would see patients and complete a full assessment, including necessary investigations. The results of this assessment would be discussed with the Urologist and a patient management plan formulated and put into action. *The aim was for nurses to investigate and for doctors to treat.* Details of assessment and plan were passed to the GP. With the support of GPs the pilot clinic started in November 1993. A synopsis of the assessments completed in the first six months was sent to GPs who were pleased with the new arrangement.

Building on early success

Despite the success of the pilot, problems arose when the Department wanted to adopt the approach at the main general hospital in Colchester. The Trust was unwilling to fund the development of a new clinic. The progress of the independent URINE charity weighed against the Department because it seemed to be ***too*** successful in raising funds that were outside of the control of the Trust. The initiative was also happening in the middle of a nursing grading review, apparently to reduce costs. Creation of a new nursing specialist role did not sit well with these plans!

It was not a comfortable time but the team were determined to press ahead because the new approach was right. They funded a urology research nurse from URINE to spend part of her time running a prostate clinic at Colchester. As at Clacton, procedures were explained to GPs and the new clinic was soon a success. After a year the value of the clinic was accepted by the Trust as an important, successful part if the Urology Department, and the Trust took over the costs of the new clinics.

What were the benefits?

In the first year of operation at Clacton, 330 patients were assessed, about six patients at each weekly clinic. Assessments took about 25 minutes. The Urologist's review of the previous week's assessments took about 20 minutes before the regular urology clinic (Table 1). The average delay from a patients' appointment with his GP to the GP's receipt of the assessment was one month. Under the old system this could have taken up to four months. GPs preferred the new approach and said that the overwhelming response from patients was favourable. Patients welcomed the thoroughness of the assessment.

Shared-care has become the preferred model for patients, GPs, specialist nurses and urologists. Nurses like the responsibility the new system gives them. The protocols have proved robust: a gold standard service. Shared care prostate clinics are now based at the main hospital (Colchester) and at three other sites. The work has strengthened working relationships between the Department and GPs. Relationships within the Trust have also improved as the success of the clinic has become known further afield through national and international publications and presentations.

Audits have echoed the detailed findings from the initial assessment at Clacton. A cost effectiveness study in 1999 showed that the cost of nurse-led clinics (£44 per patient) compared favourably with medical outpatient costs (about £50; details on **ImpAct** Internet site). This is important since the nurse, without medical intervention, can deal with between 30% and 50% of patients.

From referral to discharge

Patients no longer return to an out patient clinic for follow-up after uncomplicated endoscopic prostatic surgery. A protocol-based, nurse-led telephone service has been introduced instead. Patients are contacted by telephone 4-6 weeks after surgery to check that all is well. The protocol is designed to assess residual symptoms using a scoring system. It has proved to be safe and convenient for patients, who appreciate the reminder of advice given on discharge. Of 100 patients, only two said they would have preferred to attend a regular follow-up out patient clinic. The protocol indicated that 15 should be seen again by their GP and the remainder required no further follow-up.

Shared care and specialist nursing clinics are developing in other areas, particularly for benign prostatic hyperplasia, prostate cancer and continence. In BPH management the shared care clinic's assessment techniques are now being taken up entirely within primary care by GPs and practice nurses. URINE has continued to play a pivotal role by funding the necessary training of nurses through conference attendance and BSc and MSc courses.

Table 1: Shared care prostate clinic, Clacton. Results of first year's assessment

	Number	%
To GP with no treatment recommended	19	6
To GP with drugs recommended	71	22
To Urologist: urgent appointment	94	28
To Urologist: routine appointment	117	36
Further assessment for drug trial	15	4
Further Investigation	14	4
Total patients	330	100

Tips for success

- √ Find imaginative ways to support your ideas: creation of an independent charity can be effective but time-consuming to set up.
- √ Build on the skills of individual members of the team: look for hidden talent.
- √ Establish a clear model for what you want to achieve before you start detailed work: make sure you can see the wood in the trees!
- √ Use pilots and evaluate them so that you can convince sceptics about the value of you ideas.
- √ Don't let the ink dry on your protocols: keep making them better!
- √ Don't be deterred by organisational inertia: management involvement might help open some doors but it may not be essential.
- √ Make the service so good that ways have to be found to keep it going.
- √ Take time to persuade those involved of the benefits of your plans: not everyone will turn up to seminars!
- √ Provide educational opportunities for all levels of staff.

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The following material is available:

Prostate referral, interview and investigation protocol
Post-TURP telephone follow-up protocol
Haematuria referral / investigation protocol
Suspected urological malignancy referral proforma
Shared-care continence clinic protocol
Setting up a charitable company form

ImpAct bottom line

⇒ **Determination is a must: don't expect others to share your enthusiasm for your ideas.**

A PATHWAY TO BETTER BREAST CARE

Creating a care pathway to improve the quality of breast cancer services at Salisbury Hospital.

Why the work was started

In the mid-1990s Salisbury Hospital had introduced an informal breast care pathway and more formal care pathways, particularly in urology. Salisbury was experienced also in developing and using occupational standards. It was in a good position when the NHSE South West sought proposals in 1996 to develop a care pathway in breast cancer. Their bid was successful.

Undertaking development work

A pathway embracing the full episode of care was intended: starting with the GP, going through hospital treatment and back to discharge to primary care. A Steering Group led by Nick Carty brought together staff from the breast cancer service and those looking at the development of pathways in the Trust. External facilitators supported the work.

The care pathway was divided into five manageable pieces that could be addressed by individual teams:

- Initial consultation with the GP
- A one-stop diagnostic hospital clinic
- The inpatient episode
- Oncology
- Discharge: community and palliative care.

Doing the detailed work

Multidisciplinary teams designed each piece of the pathway. They identified key tasks, competencies and occupational standards required to deliver an optimum service. The Steering Group decided to arrange separate discussions to talk through ideas and seek views of women rather than involve them in the teams.

Work started in 1997, with 18 months development work envisaged. Each team developed its own timetable. Project-wide sessions were arranged every three months to ensure that the five pieces would fit. External facilitators managed these sessions. Progress was summarised and fed back to the Group. Facilitators made sure that *everyone said what they thought*. The sessions helped those involved get a good grasp of the contribution of others. Importantly it ensured consistent information: *different staff don't give different messages to women.*

Facing difficulties as they arose

It was not all plain sailing. It took time to engage some staff who saw themselves at the periphery of the service. Careful effort was needed: for example radiographers who only saw women at the initial stages needed to understand what happened later in the process so that they did not raise false expectations. The definition of occupational standards proved to be tedious and detailed. Nevertheless, it highlighted areas where additional staffing would be required, like clerical support and more medical and nursing staff.

The timetable was frustrating. Many sensed that the work could have been completed quicker. Indeed some changes (mammogram appointments before clinic as an example) were introduced after they had been agreed, rather than delayed until general implementation. Despite the difficulties the task was completed on time and the care pathway ready for implementation in October 1998. Key supporting documents are a referral fax for use by GPs, pre-operative anaesthetic questionnaire, patient diary and discharge fax.

Impact on services to patients

Seminars were arranged to describe the new process to GPs and explain how it would affect them. About 75% of the GPs who routinely refer women to Salisbury Hospital attended. IT support was offered. The sessions went well and GPs welcomed the new approach. Indeed the first referral fax was received in the Hospital on the day after the seminar! Since launch the Department has arranged visits to practices not involved in the seminar to explain the pathway and the use of the fax referral form.

The pathway is working well and providing a valid framework within which staff can work (Table 1). Before the introduction of the pathway, waiting times to be seen in clinic and for operation were well within guidelines. Since the introduction of the pathway these intervals have been reduced despite a big increase in the number of women seen. Intervals are more standard: for example, it is almost always nine days between the patient being diagnosed in an outpatient clinic and being admitted for operation. Better

Table 1: Salisbury Breast Care Pathway: Key measures of success

	Before pathway introduced	After pathway introduced
Numbers of patients seen each week	12-15	35
Days between referral and outpatient visit (urgent pathway)	7	4
Days between referral from GP to operation	10-40	21
Proportion of patients admitted for operation within 10 days of initial clinic appointment	40%	80%
Length of stay (days, mean)	8	3

care is being provided. Whether the process has improved health as well as reducing anxiety remains unclear.

Elements of the new service

The ***referral fax*** offers a template on which GPs can suggest urgent or soon appointment. The information allows the breast clinic coordinator to prioritise and make appointments without reference to consultants. Almost all (95%) of referrals are made using the referral fax. Most (87%) women have an appointment within 6 days.

The ***one-stop clinic*** allows an increasing number of immediate diagnoses. Previously about 60% of women could be diagnosed and counselled at their first clinic: now 95% have a one-stop investigation.

The ***pre-admission clinic*** is nurse-led. Nursing and anaesthetic assessments are completed before admission, which then occurs on the day of operation. Average length of stay has been reduced from eight to three days. Pre-admission clinics are run by a breast care and / or a ward nurse to ensure continuity when women are admitted to the ward: ***most women now see a familiar face***. Women are told that discharge is likely to be on the second or third day after the operation. They are taught how to care for their surgical drain. This caused some problems at first because nurses were not used to women leaving hospital with drains still operational. Drains are now removed in primary care.

Information for patients: each woman receives a leaflet about their initial out patient appointment. At the clinic women receive a personal plan covering diagnosis, investigations and follow up. A resource room staffed by a counsellor is available where women can get other information. A personal diary is prepared for women with breast cancer to describe proposed treatment, important dates and plans for discharge.

Patient perspectives

A survey by the CHC concluded that the *experience of the one stop clinic reported has been a generally positive one*. Women were positive about the care and treatment received. Detailed points picked up in the survey have been acted on. These included visits to practices unaware of the new process, changes to the referral form and better liaison between the Department and practices to report results. The special needs of women living alone has also been addressed.

Recognition of success

Staff are rewarded for their efforts: administrative staff (critical for the smooth running of the system) and nurses have been upgraded. The Department was awarded Beacon status in 1999. They have tackled dissemination themselves rather than rely on the national programme. They have had a good deal of success with presentations at conferences and visitors to the Department. More recently they have become involved with the National Cancer Collaborative.

Plans are already in hand to build on the progress so far. Training is being developed for practice nurses to provide care after discharge, and an induction programme for new staff. Work with GPs is exploring how they can develop their skills in assessing women and to share post-surgical management. Use of e-mail for transmitting information about referrals and discharge is also being explored.

There are some downsides. Innovation leaders find it hard to return to normal routine, as coping with stability is not exciting! There is also a danger of de-skilling for surgeons if they do not maintain their general surgical experiences.

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Tips for success

- √ External facilitators can smooth the development process: they can ask the difficult questions.
- √ Find practical ways to talk through proposals with patients: separate meetings may be more suitable than involving them in team meetings.
- √ Be flexible over time-tabling: don't defer change for a big bang. Introduce small changes as work is completed.
- √ Make the process easy for GPs: provide suitable forms and / or software to speed up the referral process.
- √ Get systems ready to meet needs for additional resources, such as increased use of X-ray and drugs.
- √ Make sure that local staff induction training gets over "how we do it here".

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ImpAct **bottom line**

⇒ **Allow time for staff involved to understand the role of others: better understanding is a key element of good team working.**